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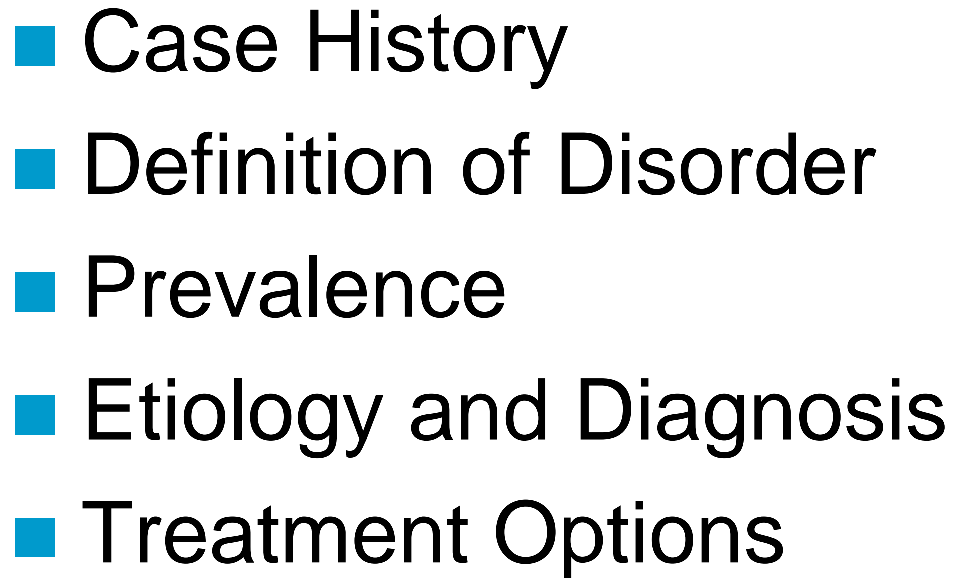


- Case History
- Definition of Disorder
- Prevalence
- Etiology and Diagnosis
- Treatment Options

Mary V

25 y.o. G0P0 on Marvelon 21

3 sexual partners-current partner for 1 year

Stopped having intercourse 2° pain 6 mos ago

Treated 6 times for yeast infections

Burning pain with penetration, worse with thrusting

Boyfriend says she is too small

‘Vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable, neurologic disorder’

- Vulvar pain with no evidence of other dermatologic explanation
- Pain is out of context with stimuli
  - Allodynia- pain in response to something not normally perceived as a painful stimulus
  - Hyperpathia-stimulus causes greater pain than would normally be expected
- Pain described as burning, irritating, sharp or prickly, rarely described as pruritic

Thomas TG, 1874

- ‘It consists of an excessive sensibility of the nerves supplying the mucous membrane of some portion of the vulva’

Skene AJC, 1889

- ‘Characterized by a supersensitiveness of the vulva. When, however, the examining finger comes in contact with the hyperaesthetic part, the patient complains of pain, which is sometimes so great as to cause her to cry out.’

- You are the 3rd person she has seen
- Told her vulva is normal so she must have chronic yeast infections and given long-term prescription for Diflucan
- Burning occurs with IC as well as touch and tampon insertion
- She has tried lubricants and no change
- She feels she is ‘going crazy’
- Boyfriend accusing her of seeing someone else
- Has irritable bowel

- Comes on only with penetration, oral sex may be ok, orgasm ok
- Tight clothes
- Partner touch
- Riding a bike
- Tampon use
- Prolonged sitting

Rule Out Other Causes

- Allergic vulvitis
- Chronic candida- needs discharge proven to be candida by microscopy or culture
- Lichen sclerosis
- Lichen planus
- Vulvar atrophy
- VIN
- Pudendal canal syndrome (unilateral usually)

Diagnosis

- History (patient localization not always helpful, i.e. deep vs. superficial)
- Physical exam
  - Normal vulva- exclude dermatoses, if uncertain treat and re-examine
  - Allodynia to Q-tip touch
    - May sometimes see hyperemia following touch

Diagnosed using Friedrich's Criteria:

- Severe pain on vestibular touch or attempted vaginal entry
- Tenderness to pressure localized within the vulvar vestibule
- No evidence of physical findings except for varying degrees of erythema

Friedrich Jr., E.G., Vulvar vestibulitis syndrome, Journal of Reproductive Medicine, 32 (1987) 110-114.

Examination

- Always look first and test with Q-tip before introducing speculum
- Indent about 3-5 mm working from outer labia in to hymenal ring
- Single finger digital exam at end to assess pelvic musculature
- +/- speculum exam

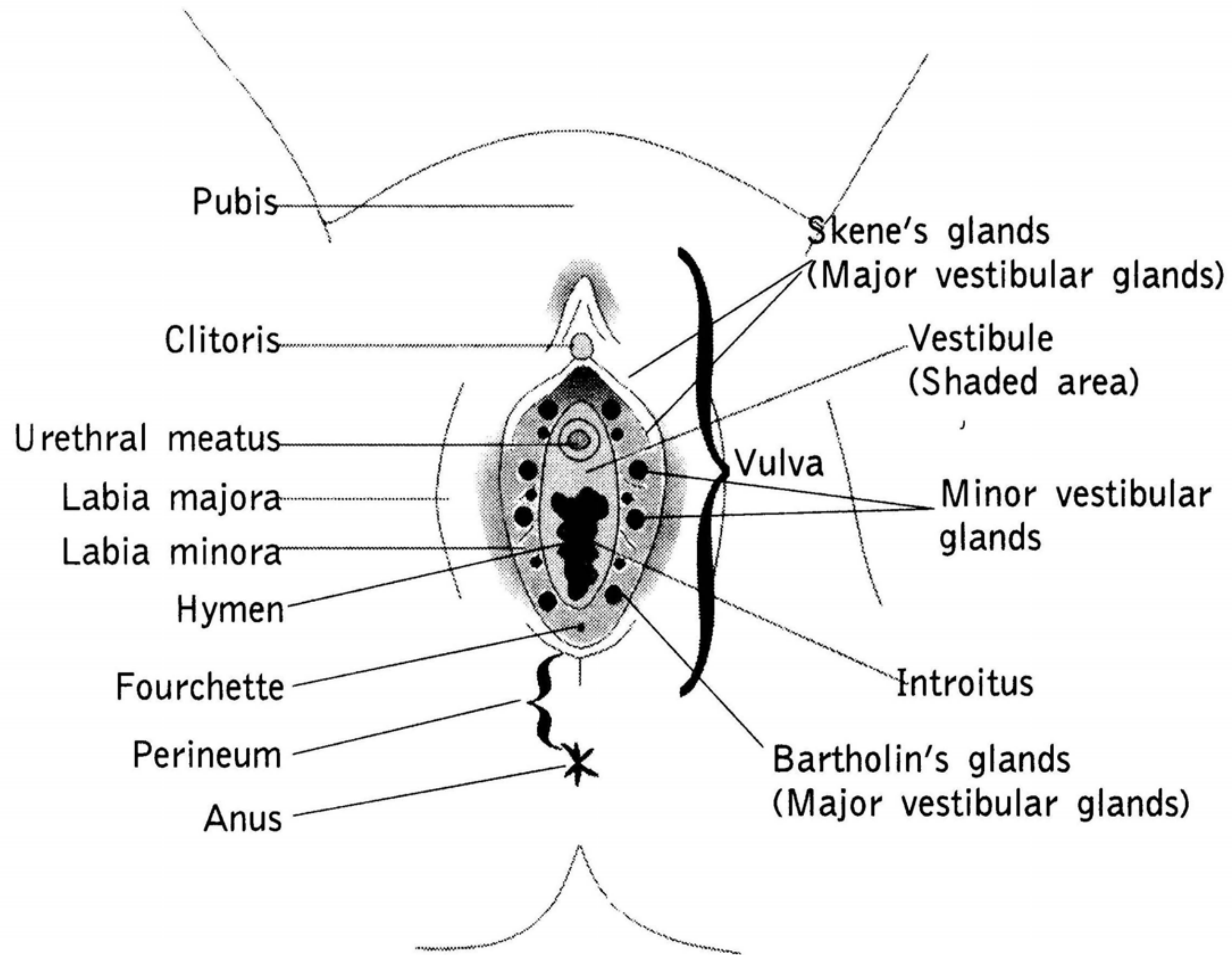


Diagram from *The Vulvodynia Survival Guide,* reproduced with permission of author, Howard I. Glazer, Ph.D.

- Generally will coexist with vulvodynia, likely a protective response
- May actually see muscles contract when you go to examine woman
- Use single finger in introitus
- Avoid speculum unless needed to rule out other diagnosis

- What it is NOT
  - Infection- HPV
  - Chronic yeast
  - Inflammation

What it likely may be

- A central or peripheral alteration of nerve function or interpretation of neural signals at the level of the cortex or the spinal cord
  - Animal models support both central and spinal cord etiologies
  - Have demonstrated lower pain thresholds at sites other than the vulva
  - ?conflicting evidence on abuse- may not be related

- Normal vulva on examination
  - No yeast on microscopy
  - No discharge
- Q tip showed +++ burning at 5 and 7 o’clock just outside hymenal ring
- Single finger digital exam showed vaginimus, pressure on muscles reproduced pain felt with thrusting

ISSVD Classification

- Vulvodynia
  - Localized (vestibulodynia, clitorodynia)
    - Provoked
    - Unprovoked
    - Mixed
  - Generalized
    - Provoked
    - Unprovoked
    - Mixed

- Essential vulvodynia
- Dysesthetic vulvodynia
- Vulvar vestibulitis syndrome
- Vulvar dyesthesia

- Localized, Provoked Vulvodynia
- Discarded term of vestibulitis to remove confusion around inflammation/infection

- Localized
  - Common
  - Age 20-50
  - 2 subtypes in my experience, always had vs. precipitated by some event
- Generalized
  - Uncommon
  - Older age, often post-menopausal
  - May have precipitants, radiation, surgery etc…

- Recent phone survey, Arnold et. al, Feb 2007
- Incidence 3.8 % (pain > 6 mos)
- Lifetime Prevalence 9.9%
- 45% Adverse effect on sex life
- 27% Adverse effect on lifestyle

Results from a self-report survey of vulvodynia patients administered by the National Vulvodynia Association

Disorder	Number surveyed	Have It	Suspect It
Chronic Fatigue	1566	12.6%	19.9%
Endometriosis	1452	15.6%	4.4%
Fibromyalgia	1547	20.0%	15.4%
Interstitial Cystitis	1662	25.2%	22.0%
Irritable Bowel	1675	34.9%	15.8%
Low Back Pain	1729	55.5%	-
Migraine Headaches	1564	31.2%	-
Chemical Sensitivities	1595	27.2%	18.2%
Other Chronic Pain	2150	40.5%	-

- Relieved to be given a diagnosis
- Wants to get more information
- Wonders if she will ever have sex comfortably again?

- Validate their problem
- Not all in their head although can have significant psychological and relationship sequelae
- Vaginismus almost always coexists

Vulvar hygiene

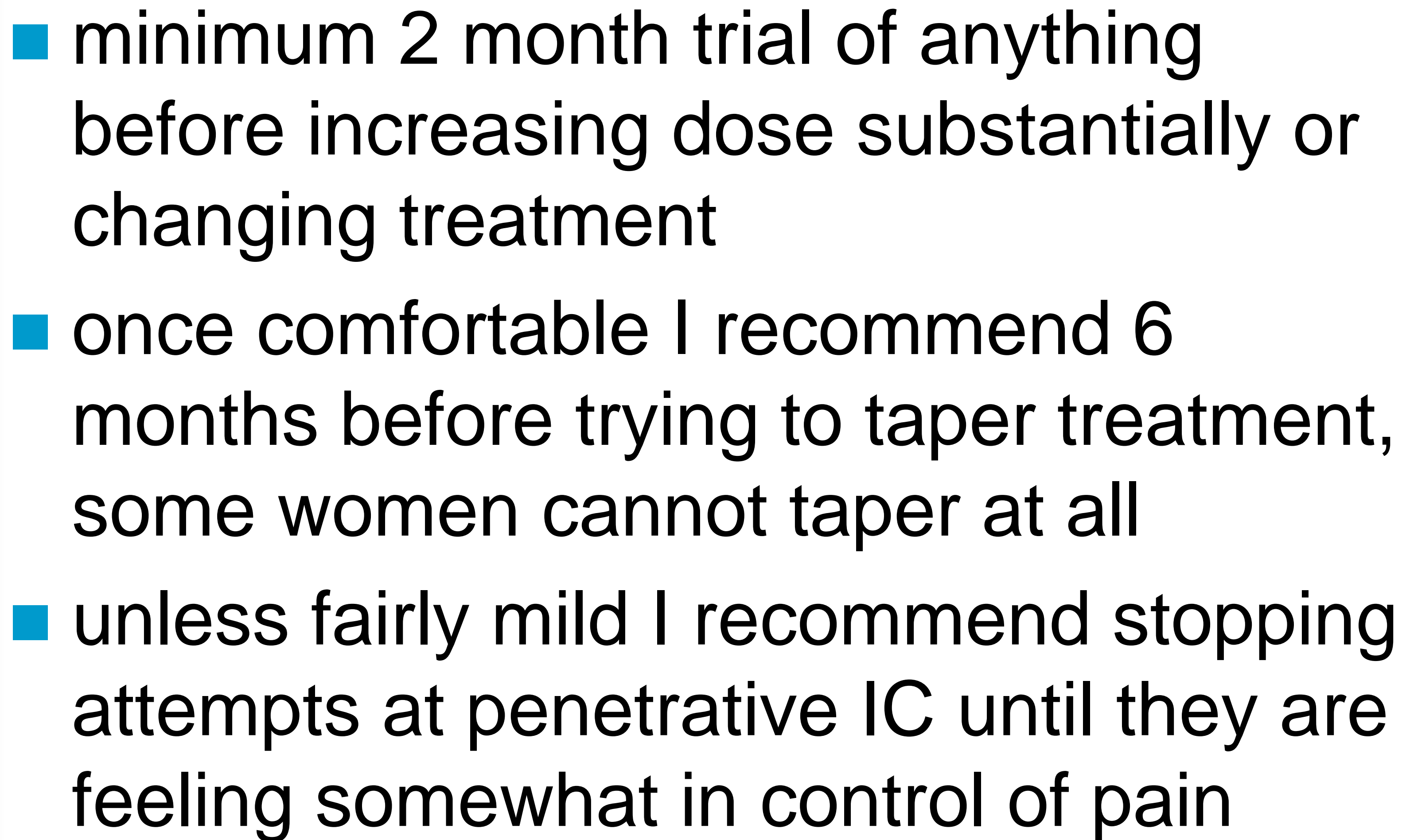
- Minimize any irritants
  - Cotton underwear
  - No fabric softeners or dryer sheets
  - Non-irritant soaps to vulva and clothes, Dove or water only, Ivory Snow for wash
  - No scented products
  - Underwearless as much as possible
  - Avoid pantyhose

- Particularly around menses
  - Silicone barrier creams
  - Vaseline
  - Zincofax etc…
- Lubricants **always** with intercourse
  - KY liquid, Astroglide, Slippery Stuff, Oh My!
- Some woman may manage with just xylocaine 2% jelly prn

- Mainly based on expert opinion, few controlled trials with significant numbers of patients

- Treatment goal is to get her comfortable most of the time, may not be absolutely pain free and may fluctuate over time
- Some woman seem to have a natural improvement
- No long-term studies on natural history
  - My experience is that recent onset more likely to improve
  - Lifelong very difficult and Generalized very difficult

- No real data
- Most treatment studies will show approx. 70% improvement
- Some suggestion that overall about 50% of women will improve
- I see large numbers of referred women and infrequent that we can’t find something that will help to some extent


minimum 2 month trial of anything before increasing dose substantially or changing treatment
once comfortable I recommend 6 months before trying to taper treatment, some women cannot taper at all
unless fairly mild I recommend stopping attempts at penetrative IC until they are feeling somewhat in control of pain

- Topical Medications
  - Estrace 0.01% in Glaxo base, qhs or bid
  - Xylocaine 2% jelly qid or prn (can also try EMLA, avoid benzacaine)
  - Amitriptyline 2%/baclofen 2% in water washable base
  - Zostrix- topical capsaicin- apply for 20 minutes and wash off- counter-irritant

- antifungals
- corticosteroids

If these are necessary then they need re-evaluation to see if they actually have vulvodynia

- Tricyclic antidepressants
  - Amitriptyline
  - Nortriptyline
  - Desipramine
    - start low and go slow, 10 mg nightly, increase after 2 weeks, leave at that dose for 6 weeks
    - I go up to 75 mg if tolerated
    - do not stop suddenly, wean

- Venlafaxine (Effexor XR)
  - 37.5 mg daily
  - increase after 1 month to 75 mg
  - can go up to 150 mg
  - wean slowly!!!

- Anticonvulsants
  - Gabapentin (Neurontin)- 300 mg daily, increase weekly by 300 mg until tid
  - can go up to 3600 mg but I usually stop at 1800 mg
  - Carbamazepine- I have never used
  - Pregabalin (Lyrica)- 75 mg bid and increase after 1 month to 150 mg bid

Trigger Point Injections

- Occasionally helpful when there is just one or two painful spots only
- 1 injection of 2-4 mg Kenalog in xylocaine 1 or 2%, if helpful can repeat once

Low oxalate diet

- ??????????????????????????

- Biofeedback/pelvic floor physiotherapy
  - need to find someone in your area
  - we have one physiotherapist with this interest in Halifax area
  - abnormally high tone in pelvic floor a common problem, also helps with vaginismus

- Left as last resort, generally vestibulectomy, sparing urethral area

- accupunture
- Botox
- many ‘natural’ products

- Must be addressed as well
  - physiotherapy/biofeedback
  - ‘reverse’ Kegel exercises
  - dilators, vibrator or candles

- mostly supplying information
- try to involve partner, often complex sexual dynamics by the time diagnosis is made

- initially on Estrace with mild improvement
- added amitriptyline but couldn’t tolerate 20 mg because of sedation
- changed to nortriptyline and found improvement of 50%, up to 35 mg nightly
- added qid topical xylocaine jelly and got 80% improvement
- has worked on reverse Kegels and has IC most occasions comfortably

- This is a pain disorder
- Multiple treatments
- You won’t be able to fix everyone but you can help a significant number of women
- Don’t underestimate the importance of being able to give them a diagnosis and just listening

- www.ISSVD.org
- www.NVA.org
- www.vaginismus.com

Books

- The V Book: A Doctor's Guide to Complete Vulvovaginal Health
  by Elizabeth Gunter Stewart, MD and Paula Spencer
- The Vulvodynia Survival Guide: How to Overcome Painful Vaginal Symptoms & Enjoy an Active Lifestyle
  by Howard I. Glazer, Ph.D. and Gae Rodke, M.D.